BRAND NAME

NH Medicaid Prior Authorization/ Non-Preferred Drug Approval Form

New Hampshire

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

SECTION I: Patient Information and Medication Requested

Name (Last, First): _____ Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Directions:_____ Length of Therapy: _____

SECTION II: Clinical History

1. Patient's diagnosis: _____
2. Was a MedWatch form completed and submitted to the FDA regarding treatment failure on generic medication? ☐Yes ☐No
3. Has the patient experienced a therapeutic failure or adverse reaction to a generic form of this drug or have a specific allergy to generics? ☐ Yes ☐ No
4. Would changing the medication to another generic in the same therapeutic category represent an unacceptable risk to the patient? ☐ Yes ☐ No
5. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

SECTION III: Non-Preferred Drug Approval Criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction ☐ Drug-to-drug interaction. Please describe reaction: _____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.
Please provide clinical information: _____

☐ Age specific indications. Please give patient age and explain._____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference.

☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

SECTION IV: Prescriber Information

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider

Revised 5/1/05